in that country as a public health problem. What undoubtedly exists in China is a lack of adequate communicable disease surveillance and reporting, just as we see throughout the world, including much of the United States. It is often politically fashionable and expedient to deny existence of a public health problem to outsiders.

In the United States in 1978 there were 21,681 reported cases of primary or secondary syphilis and a million cases of gonorrhea. Eight states accounted for 75 percent and 50 percent of these cases, respectively. Between March 1976 and December 1978, there were only 508 reported cases of penicillinase resistant gonorrhea in the nation, of which 289 were from California. Thus, many of the nearly 400,000 practicing physicians in the United States can also say they see very little or no syphilis or gonorrhea in their practices. Fortunately, our medical schools have not used their lack of teaching cases as an excuse to stop teaching about venereal disease.

The commentary coming out of China sounds like the talk of venereal disease eradication in the United States during the middle and late 1950's. In 1957, only eight cases of infectious syphilis (mostly secondary) were reported for the million people residing in Seattle-King County and many areas of the country had no cases, despite the continued existence of prostitution. I doubt whether the Chinese have solved the problem of homosexual transmission of venereal diseases and I question if they have a lesser problem with antibiotic resistant gonorrhea than we do. Furthermore, many Chinese females and males probably also develop asymptomatic infections of gonorrhea and syphilis and do not know they are infected. Venereal disease is likely to remain a public health problem worldwide for years to come.

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Thoughts After Three Mile Island

TO THE EDITOR: One is fascinated by the recently popular discovery that we arise from previous generations. We are beginning to feel strongly that we have roots in the past. The biological mysteries of intimate blood relationships with men and women and children who precede us, entrance us.

We are beginning to know that our lives and the facts that we can love and breathe and laugh and cry, that we can help and touch one another, that we can hold a baby in our arms and that we can hear the ocean in a seashell—all these and all other sensations that we might have, we have received from those who went before us. From our roots.

We are sad about any suffering that our ancestors might have endured, feel puzzled and perhaps a little guilty at the pain that they might have inflicted on others, individually or during war and holocaust, and wonder at the fact that so many of our antecedents often suffered as a result of the selfishness and arrogance and greed of a few.

Now we are at the watershed. The fact of man-made alterations of the environment on a massive and accelerating scale, has put our generation in a critical relationship to future generations.

Above all looms the threat of radiation concentrated or created by man. No other environmental threat is more fraught with hazard to us and to those whose roots we are and will have been 5, 10, 20, 100 generations from now.

Between 1898, when the Curies discovered radium and its phenomenal property of radioactivity, and the year 1938, just before World War II, the total world supply of radium was less than 600 grams (1⅓ pounds), an amount that would not make a 2-inch cube. Of this, 225 grams were in the United States. The tiny quantity each fortunate hospital in the world might have owned for therapeutic purposes was guarded with an almost ritualistic reverence because of a mixture of respect for its healing properties and concern because of the danger of the invisible and potent radiation that it was constantly emitting.

Now, as a result of nuclear weapons programs and nuclear power plants, we have produced thousands of billions of grams of equally radioactive substances such as plutonium and strontium and tritium and iodine and carbon and xenon and krypton and on and on. And while we wonder what we are to do with this deadly cargo that for generations can cause cancer and can deform the genetic heritage that we carry within us, we keep cooking up our witches' brew as if we have gone mad.

The atom, this tiny particle of matter which we must imagine in our minds because we cannot see it, dominates the minds of many and has infected the brains of our leaders, much as if it were a virus. It has bred ideas of arrogance which make us believe that we can forever dominate nature;

this virus of the atom has bred greed to go along with our arrogance of power, so that we believe in our concept of never-ending growth, as if we ourselves have become a cancer on the planet.

Where are the statesmen who would have the courage to say: Let us now pause. Let us be humble before nature. Let us be silent for a moment and let us listen. Perhaps we will be able to hear the voices of generations yet unborn, thanking us for our wisdom, expressing their gratitude to us for pausing a while, for having the courage to admit that we are lost on a dark and dangerous trail, and for having the good sense to be cautious.

Let us recall the words from the Russell-Einstein Manifesto, read by Bertrand Russell on July 9, 1955:

> There lies before us, if we choose, continual progress and happiness, knowledge, and wisdom. Shall we, instead, choose death, because we cannot forget our quarrels? We appeal, as human beings, to human beings: remember your humanity, and forget the rest. If you do so, the way lies open to a new Paradise; if you cannot, there lies before you the risk of universal death.

Let us remember our humanity, and forget the rest.

How little we will lose, and for such a short time, if we would just pause. But by not attending to the cancer of growth and more growth, very soon we stand to lose everything in a final firestorm. Whose roots will we then have been?

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Patient Care Audits

TO THE EDITOR: The letter of Thomas Wynn in the May issue (Patient Care Audits Not Cost Effective) raises an excellent point concerning patient care audits.

For these audits to be effective, either as a teaching aid or in reducing costs, physicians must make the same mistake repeatedly in the care of patients or many physicians must make the same mistake. This simply is not realistic. On those occasions where mistakes occur, they will continue to occur as they always have—a given physician caring for a given patient will either fail to do something he should or do something he should not. All of the patient audits that have ever or will ever be done could not correct this.

Out of curiosity several years ago, we set aside one month in the city of Glendale, California, and monitored the number of hours donated by physicians on hospital staffs in those functions not directly related to patient care. We had the man-hours donated for committee meetings and staff meetings tallied, specifically excluding the additional hours given by the officers of the staff and also excluding all educational activities. In the four major hospitals in Glendale, we averaged more than 300 man-hours per hospital per month donated in noncare services. This is, for the most part, wasted time. It is difficult to consider any other field in which this amount of time and effort would be donated gratis. As long as we are willing to do so, I believe the demand will increase endlessly. Only when the profession as a whole takes the stand that Dr. Wynn and I have taken in refusing to pursue these exercises of futility will they finally come to the end they so richly deserve.

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TO THE EDITOR: As chairman of the Quality Assurance Committee for the San Francisco Peer Review Organization (SFPRO), I would like to respond to the points raised in Dr. Thomas Wynn's letter in the May issue (Patient Care Audits Not Cost Effective).

First, many San Francisco physicians share his concern that some medical audit programs do not have an impact on quality of care and are nonproductive activities. However, there are mechanisms in place in some San Francisco hospitals which make this activity fruitful and meaningful for medical staffs, without an inordinate expenditure of time or money. By focusing on quality of care *problems* as the basis for audit topics, limiting the number of criteria items to a maximum of ten and audit samples to 20 to 30 cases, the costs of performing medical audits are substantially reduced. It is then the responsibility of the hospital medical staff and governing body to take corrective action and monitor those actions when quality of care problems are identified. This can occur in the majority of audits performed if actual or perceived problems are chosen at the outset of an audit study. This is why SFPRO is pushing the concept of generic screening (problem-oriented audit), which is being taught at the California Medical Association/California Hospital Association Audit Workshops.

It is unfortunate that Dr. Wynn's experience